HEALTH INSURANCE IN CALIFORNIA: FACING THE PROBLEM, FINDING SOLUTIONS

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Californians long have been more disadvantaged in health insurance coverage than the average American. Compared with the nation as a whole, a smaller proportion of Californians are protected by employment-based health insurance and a larger proportion are uninsured.

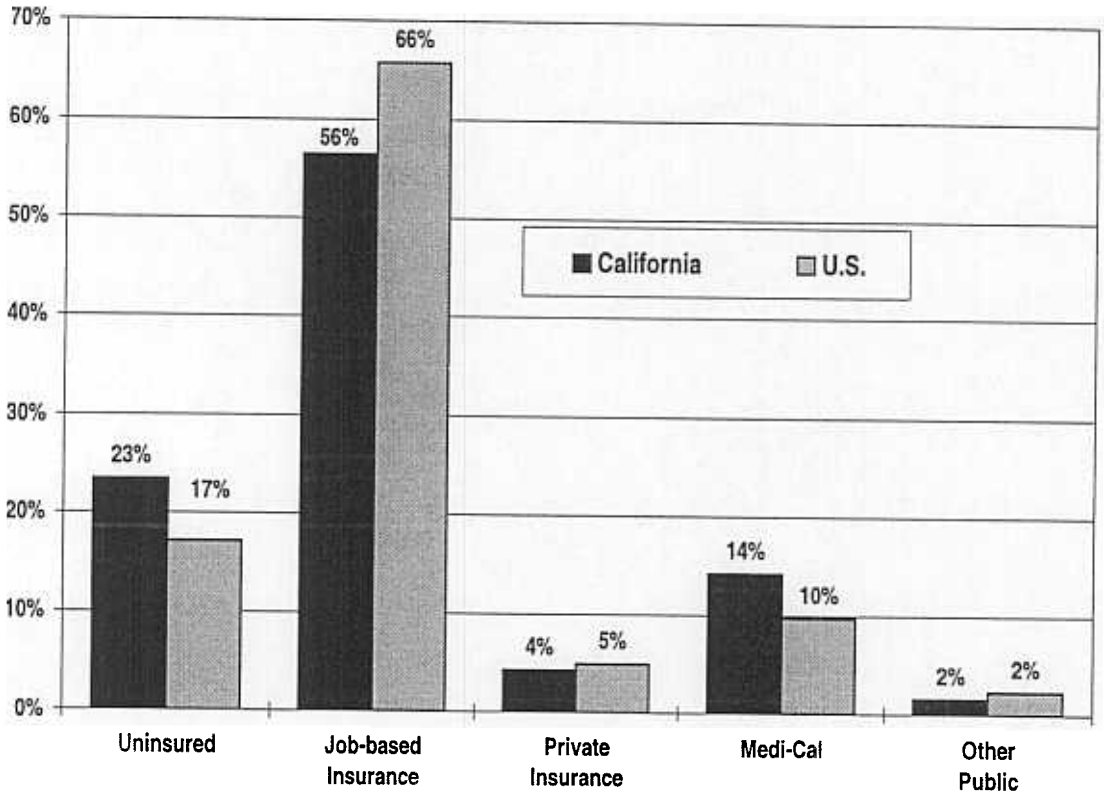
A little over half (56%) of nonelderly Californians have job-based health insurance, compared with two-thirds (66%) of all nonelderly Americans (see Figure 1). One-fourth (23%) of all nonelderly Californians—6.6 million children and adults—are uninsured, substantially more than the one in six (17%) of all nonelderly Americans who have no private insurance or public coverage.

The deficits in California's employment-based coverage are not offset by the private purchase of health insurance, which covers only one in 20 nonelderly in California and nationally (Figure 1).

Medi-Cal (California's Medicaid program) provides coverage to one in every seven Californians, including one in every four children. Compared to the national average, a larger proportion of nonelderly Californians receive their health care coverage through Medi-Cal. This disparity reflects both the state's relatively generous eligibility provisions for Medi-Cal and the state's relatively high poverty rate. The public Medi-Cal program thus offsets partially the lack of private coverage. Without Medi-Cal, an even larger share of the population would be without any coverage.

California's higher rates of uninsurance and lower rates of employment-based have persisted for nearly two decades.[1] As we seek ways to assure health care access and financial protection against medical expenses for all Californians, we must understand the extent of current problems and the factors that contribute to them. In this chapter, we will address several policy questions: Who are these

Figure 1. Health Insurance Coverage of Nonelderly Population, Ages 0-64, California and US, 1994



Source: March 1995 Current Population Survey

uninsured Californians? Why do we have a larger problem of uninsurance than does the nation as a whole? And what issues do we need to take into account in developing policies to extend health insurance coverage to all Californians?

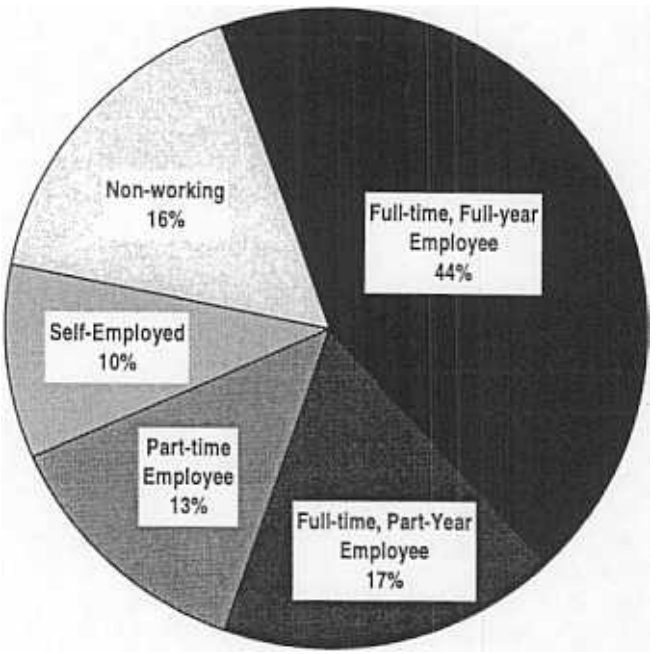
Who Are the Uninsured?

California's uninsured population includes 1.8 million children, more than one in four of all the uninsured. Nevertheless, nonelderly adults are more likely than children to be uninsured (25% versus 20%).

Uninsured Californians are overwhelmingly a working population. More than eight in ten uninsured are workers or in a family headed by a working adult (see Figure 2). Six in ten of the uninsured (61%) are full-time employees and their family members.

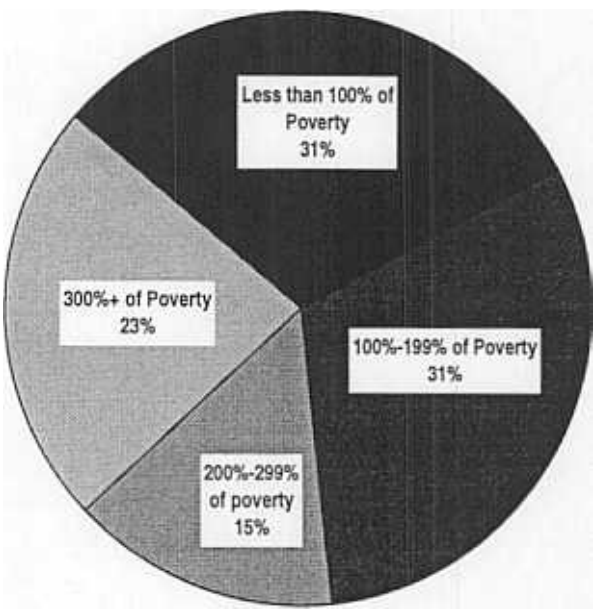
Although self-employed workers and their family members account for only one in ten of the uninsured, they have the highest uninsured rate of any family work status. Among all adults and children in self-employed worker families, 46% are uninsured. In contrast, only 17% of persons in full-time full-year employee families are uninsured. Because this latter group comprises 60% of the nonelderly population, it contributes the largest share of the uninsured. We will examine the relationship between uninsurance and employment in more detail. Despite the fact that the great majority of the uninsured are workers or in working families, two-thirds of the uninsured have very low family incomes. Almost one-third are poor, and an equal number are near poor, with family incomes below 200% of the federal poverty level (Figure 3).[2] The low incomesof most of the uninsured require that both market- based and public policy approaches to extend coverage

Figure 3. Family Income of Uninsured Persons, Ages 0-64, California, 1994



Source: March 1995 Current Population Survey

Figure 2. Family Work Status of Uninsured Persons, Ages 0-64, California, 1994



Source: March 1995 Current Population Survey

to this population include financial assistance for these individuals and families if such efforts are to be successful. The good news is that nearly one in four (23%) of the uninsured have incomes at least 300% of the poverty level—a level sufficient to enable them to help pay for some, but in most cases not all, of the premium costs. We will necessarily return to this point again.

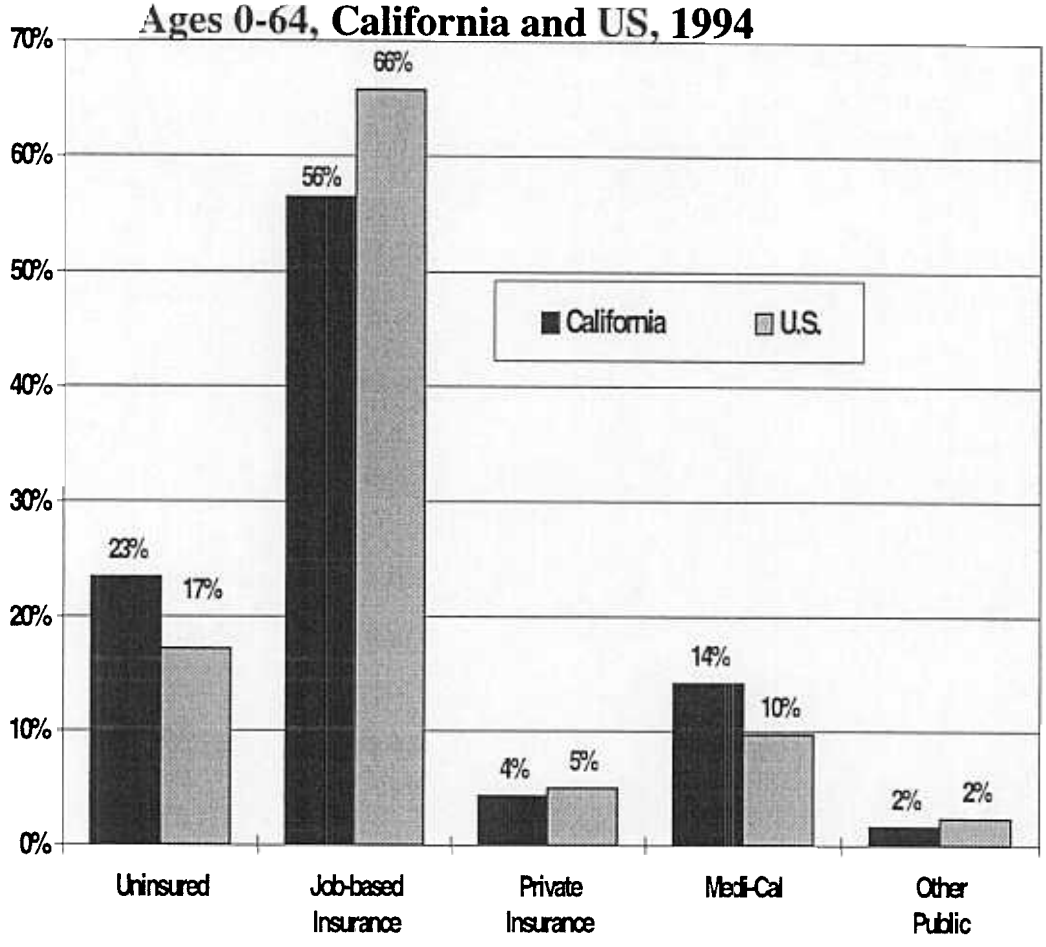
Why Is California's Uninsured Rate Higher than National Average?

Uninsurance, as we have seen, results largely from the working uninsured not receiving the employment-based health benefits that still protect most workers and their families. Nearly two-thirds (64%) of all Californians in working families receive health insurance through their own or a family member's employment, but one in four (25%) have neither job-based coverage nor any other type of private or public coverage and are completely uninsured. The greater absence of employment-based health benefits among California's working families helps explain the state's higher uninsured rate.

Californians are less likely than other Americans, even in comparable working families, to receive job-based insurance. Among persons in full-time full-year employee families—those most likely to receive employment benefits, 75% of Californians are covered by job-based insurance, compared with 81% nationally (see Figure 4). Among families with a full-time part-year employee (one who works less than 50 weeks during the year), only 44% of Californians received employment-based health insurance, compared with 52% nationally. And among part-time employee families (i.e., with an employee who works fewer than 35 hours a week), 38% of Californians receive job-based insurance, compared with 45% nationally. The largest disparity is among self-employed working families—the most disadvantaged with respect to health benefits:

only 22% of Californians are covered by health insurance obtained through employment, compared with 31% nationally.

Figure 4. Percent Job-based Insurance by Family Work Status,
Ages 0-64, California and US, 1994



Source: March 1995 Current Population Survey

In addition to families in all working groups having lower rates of job-based coverage, smaller proportions of Californians are full-time full-year employees or in families headed by someone with such stable employment. Only 60% of nonelderly Californians are in

full-time full-year employee families, compared with 65% nationally. And among adults ages 18-64, 49% of Californians work full-time for the full year, compared with 52% nationally. Thus, California's uninsured rate is higher than the national average both because less of its population works in the most advantaged types of employment—full-time for the full year—and because, whether full-time or part-time, employee or self-employed, a smaller proportion of Californians have job-based coverage.

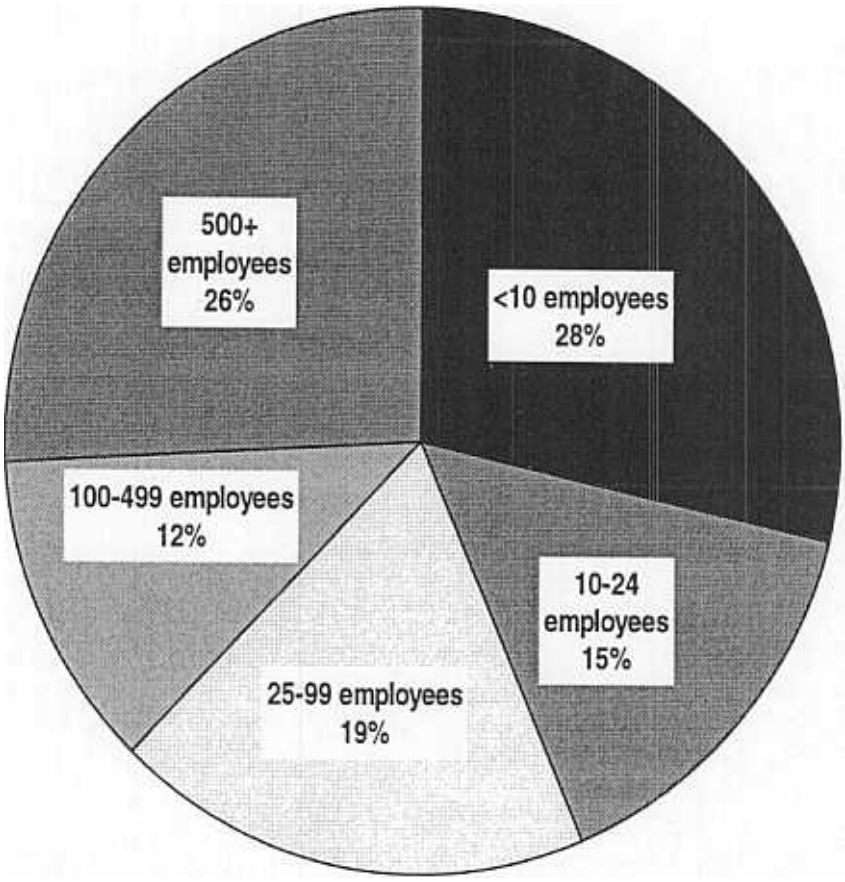
Lower rates of coverage also are associated with other employment characteristics. About half of all uninsured employees work in the retail, service or agricultural sectors of California's economy, a disproportionate share of the problem. These sectors—together with construction, durable goods manufacturing, and wholesale trade—are much less likely to provide health benefits to their employees. Compared to the nation as a whole, a smaller proportion of California's full-time full-year employees receive health benefits in all sectors of the economy except the public sector.

Uninsurance among employees is concentrated in small firms, but large firms also contribute to the problem. More than one-fourth (28%) of all uninsured employees work in very small firms (fewer than 10 employees) and another 15% work in firms only a little larger (10-24 employees; see Figure 5); a majority of uninsured small-firm employees work full-time for the full year. One-fourth (26%) of uninsured employees work in large firms (500+ employees), although these employees disproportionately work part-time. Fewer than half (43%) of employees in very small firms and just over half (53%) of employees in firms with 10-24 workers receive job-based health benefits. Although 82% of employees in large firms receive these benefits, nearly half of all employees work in large firms, which greatly amplifies even their relatively modest uninsured rate.

Although California employees are about as likely as the average American to work in either very small firms or large firms, Californians are less likely to receive job-based health benefits in

firms of any size. Even among full-time full-year employees, only 48% of Californians who work in very small firms receive job-based benefits, compared with 59% nationally (data not shown). The California-national differences narrow with increasing firm size, but the gap remains.

Figure 5. Uninsured Employees by Firm Size, Ages 18-64, California, 1994



Source: March 1995 Current Population Survey

The California-national disparity in coverage of the working population reflects, in part, the lower proportion of California employers who offer coverage. One-third (34%) of California firms with 5-50 employees do not offer health benefits to any employees, compared with one-fourth (24%) of such firms nationally. Although the differences are smaller among larger firms, fewer California firms of all sizes offer health benefits to their employees.[3]

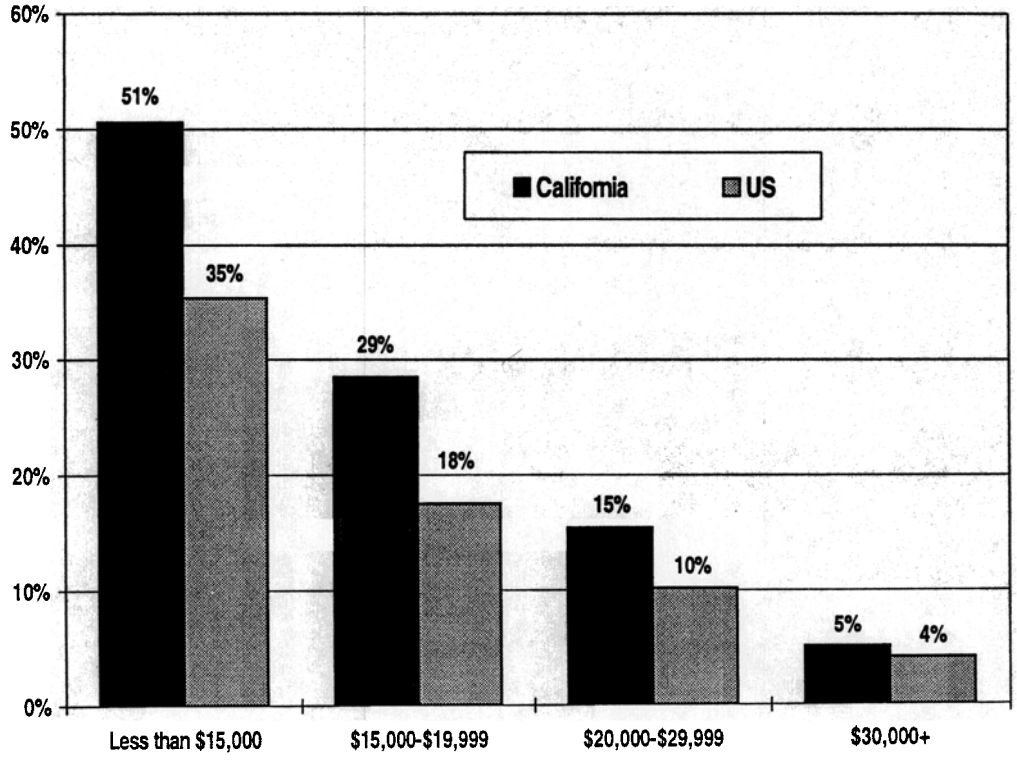
Smaller firms are thus a clear source of the uninsured problem. They have little clout in the health insurance market and, in an experience-rated market, carry more volatile risks for insurers. Consequently, small firms face substantially higher premium charges than do larger firms, a major deterrent to these employers offering coverage to their workers. In addition, many small employers who do not offer benefits are in the retail and service sectors of the economy. These firms tend to employ less skilled workers, who are less able to demand health benefits. Moreover, the profit margins of these firms may be small, reducing the affordability of health benefits. Indeed, employers cite the high cost of health insurance premiums and the firms' own financial difficulties as their major reasons for not offering benefits. And uninsured employees report that their employer's failure to offer health benefits is a major barrier to their obtaining coverage.[4]

The low incomes of a large ortion of the uninsured suggest the important role that income plays in the problems of health insurance coverage. Nearly four in every ten nonelderly Californians below 200% of the poverty level (just over $30,000 for a family of four) are completely uninsured, compared with just over one in ten of those with family incomes at least three times the poverty level ($45,423 or more for a family of four). Compared to the United States as a whole, a larger proportion of Californians is uninsured in each family income group, including the highest.

A similar pattern is evident among employees themselves. Among full-time full-year employees, one in every two very low-wage employees (those earning less than $15,000 per year) and one in every three who earn $15,000-$19,999 are uninsured in California, compared with only 5% of those earning $30,000 or more (see Figure 6). At lower-wage levels, California's uninsured rates are substantially higher than the national average.

The clearly inverse relationship between wages and uninsurance translates into a substantial need for financial assistance to enable these employee to participate in any health benefits programs. With nearly two-thirds of uninsured full-time full-year

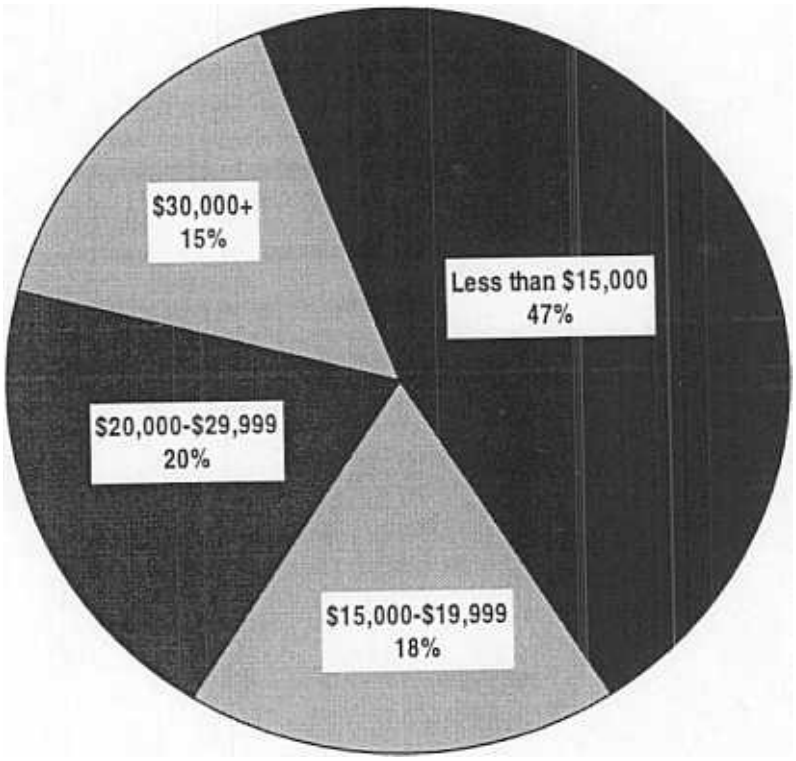
Figure 6. Percent Uninsured Among Full-time Full-year Employees by Annual Earnings, Ages 18-64, California and US, 1994



Source: March 1995 Current Population Survey

provision of an employer contribution or other financial subsidy for health insurance coverage is obviously critical.

Figure 7. Uninsured Full-time Full-year Employees by Annual Earnings, Ages 18-64, California, 1994



Source: March 1995 Current Population Survey

Reflecting their relative positions in the economy, minorities experience more barriers to health insurance coverage than do non-Latino whites. Latinos have the highest uninsured rate (36%) and the lowest proportion covered by job-based insurance (39%), as one might expect given many Latinos' more disadvantaged position in the labor market. Just 16% of non-Latino whites are uninsured and 69% have employment-based coverage. Asians and African Americans fall in between with 23% and 20% uninsured, respectively; 52% of both groups are covered by employment-based insurance.

We find similar patterns even among full-time full-year employees in California: 59% of Latinos have job-based insurance, compared with 77% of Asian full-time workers, 82% of African Americans, and 88% of non-Latino whites. Conversely, 37% of Latino full-time workers are uninsured, compared with 16% of Asians, 12% of African Americans, and 8% of non-Latino whites. The relative disadvantage in health insurance benefits experienced by minorities, especially Latinos, is clearly related to their employment in sectors of the economy and occupations that bring lower wages and few benefits.

Policy Issues

Many of the 6.6 million Californians who are uninsured experience serious barriers to accessing health services. A recent national study found that 53% of the uninsured experienced significant problems in obtaining needed medical care and/or paying their medical bills.[5] These findings are consistent with many other studies that emphasize the toll that lack of health insurance imposes on individuals and communities.

In addition to the cost in lives, health and personal debt, widespread uninsurance imposes substantial economic costs on communities, including on those who are already paying a substantial share of our society's medical costs. Many poor and near-poor working families with children obtain care with the financial assistance of Medi-Cal coverage, while other working families and individuals seek needed care from county health services programs and from private-sector and community-based providers. Public-sector expenditures for Medi-Cal and county health services include the costs of providing care to employees and their families who do not receive job-based health benefits. The fact that nearly two-thirds of

nonelderly Californians still receive health insurance through their own or a family member's employment suggests that we may view these expenditures as a shift of costs from employers who do not provide job benefits to other taxpayers. This cost-shift carries substantial fiscal consequences. In 1992, public programs in California spent nearly $4 billion—$3.2 billion in Medi-Cal program expenditures and $795 million spent by state and county indigent medical services programs—to provide health services to children and adults in employee families not covered by employer-provided health benefits.[6]

Employers who help pay for their employees' health benefits, in effect, pay three times. They pay the costs of coverage for their own employees. They pay a second time in the form of a hidden surcharge on their employees' health benefits to pay for private-sector services used by the uninsured.[7] And they pay a third time through their taxes, part of which fund Medicaid and county health services provided to working families not covered by job-based health insurance. Employees, of course, also share in all these financial burdens.

California's long decline in private health insurance coverage is not likely to be reversed without deliberate and significant government action. Economic pressures on wages and benefits paid by employers, due both to the globalization of California's economy and the high cost of health benefits, is likely to continue to erode employment-based health insurance. With the growth of the contingency labor force—contract workers, part-time and temporary employees—increasingly replacing permanent full-time employees, we are likely to see this trend accelerate. In the absence of employers providing affordable coverage to their employees, we are likely to see a continuing rise in the number of uninsured and the rate of uninsurance.

The relatively low incomes of uninsured workers and their families reflects an important part of the problem. Not only are employers dropping health benefits, they are also cost-shifting

premiums to their employees: increasing employees' share of cost for premiums and for health services. This trend coincides with a decline in the wages of many workers, making the employee's share of cost unaffordable. Forced to choose between paying for health insurance or putting food on the table and paying rent and utilities, most families and individuals will favor their most immediate necessities and hope that they will not need expensive medical care. These workers and their families are much less likely to receive preventive health services and care for acute and chronic conditions, a problem that may have especially serious health consequences for persons in poor health. And, when high blood pressure, diabetes, or asthma is not properly managed through primary care, severe acute episodes are likely to occur with life-threatening and disabling consequences for the individual and substantial medical costs for the community.

Any solution to the problem of uninsurance will require substantial subsidies. Without assistance, health insurance is simply unaffordable for most working families and individuals, especially those who are currently uninsured. The nearly two-thirds of the uninsured population below 200% of the poverty level will need financial assistance to cover most of the cost of their insurance, but even those above this level will require subsidies. For a family earning, say, $36,000 a year, a basic family health plan that costs $300 per month would consume 10% of the family's gross annual income—just for health insurance premiums. Public policies may mandate individuals to buy health insurance, or they may make it attractive to lower-income uninsured working families and individuals. In either case, health insurance must be affordable and be perceived as affordable, and significant subsidies will be necessary to accomplish that objective.

There are only two broad sources for such subsidies: employers and government. Employers have provided health insurance benefits if they are necessary to attract and retain employees in the firm's labor market or because of collective bargaining agreements with unions, incentives that are much weaker now than in the past. Because two-thirds of California employers still provide

health benefits and two-thirds of the state's population receive job-based coverage, we may yet achieve political consensus that employer-provided health benefits should be an entitlement of work. The absence of that entitlement contributes to the downward trend in employers' offering health benefits and employees' inability to obtain coverage. If employers are required to pay for coverage, additional government subsidies will be needed by small and economically marginal firms. The importance of these subsidies is evident given the financial difficulty that now discourages many employers from offering health benefits. However, the contentious debate over whether employers should be required to contribute to employees' health benefits was one of the major factors that doomed the recent national attempt to make health care coverage universal. The provision of generous subsidies to small businesses did little to assuage the opponents of mandating employer coverage or contributions to coverage.

Several states have opted to cover substantial portions of the working uninsured through their Medicaid programs. Tennessee and other states have used federal Section 1115 waivers to expand eligibility for revamped Medicaid programs, enabling uninsured families above the state's basic income eligibility to buy into the program.[8] These reforms include transforming Medicaid from a fee-for-service program into a system of contracts with managed care plans, a change that is already well underway in California.

Expanding Medicaid into a program that includes the lower-income uninsured is attractive for many reasons. First, this approach makes use of existing funding streams from the federal and state governments. It allows states to fund at least part of the expanded coverage with federal funds and by realizing savings that accrue from moving Medicaid beneficiaries into managed care. Second, it recognizes the reality that the situations of many lower-income families change frequently. Absent more unifying coverage options such as these, many working families and individuals experience alternating periods of uninsurance, private health insurance, and Medicaid eligibility. Third, this approach reduces stigmatizing

distinctions in these public benefit programs, avoiding classifying some beneficiaries as part of a public assistance program (Medicaid) and others as qualifying for programs open only to working families.

Despite these advantages, this approach has at least one important limitation in California: the low per capita expenditures for Medi-Cal beneficiaries. California has driven health expenditures per Medi-Cal beneficiary to a very low level through a variety of constraints on provider payments. Although this may be good from a fiscal perspective, it leaves virtually no margin to reap savings that other states realize when they move their Medicaid programs from fee-for-service to managed care. Thus, Medi-Cal expenditures are already very thin, so that spreading them further to include low-income uninsured residents, as well as Medi-Cal beneficiaries, is not very feasible. Therefore, California should expect to pay the full costs of expansion with new state or federal moneys, not by spreading existing Medi-Cal expenditures more widely.

Minnesota, Washington State and other states have expanded coverage of formerly uninsured families and individuals through state health insurance reforms. These reforms involve a variety of mechanisms that typically include expanding public risk pools and health insurance purchasing arrangements, substantial state subsidies for low-income uninsured residents, and reforms in the small-group and individual health insurance market. These reforms may extend eligibility to all low-income population groups or be focused more narrowly on particular groups.

One option now being discussed widely at the state level as well as nationally is to develop programs that would cover all children in a state. Children are relatively inexpensive to cover. Moreover, Medi-Cal eligibility is quite generous toward infants and young children, during the ages when health expenses are typically greater, although many children who are potentially eligible for Medi-Cal remain uninsured. In California, 1.3 million children below 200% of poverty are uninsured, including one-half million below age 6 and more than three-quarters million ages 6-17. Many observers believe

that providing public programs for children has substantial political appeal, but this premise may be questioned in light of recently enacted national policies that impose major budget cuts on programs targeted to children and their families.

A program to cover children or other uninsured groups could be developed as a universal public program, intended to replace a patchwork of public and private arrangements, or as an incremental program, designed to fill in the gaping holes in the present system. A universal program would convey benefits to a broader population, generating broader political support. Although universal program would require larger government outlays, it may be considerably less expensive per person covered, generating much less administrative expense. Any incremental program to expand coverage must take steps to avoid displacing private voluntary insurance coverage, which could occur if employers or employees decide to discontinue private coverage because a public program becomes available.

Regardless of what options are chosen, California can ill afford to permit the health insurance coverage of its residents to continue its long decline. The health of children and adults and the continued financial viability of the state's health system require policy makers to address this long-festering problem.

[1] Brown ER, Valdez RB, Morgenstern H, Nourjah P, Hafner C, *Changes in Health Insurance Coverage of Californians, 1979-1986.* Berkeley: California Policy Seminar, University of California, August 1988; Brown ER, Valdez RB, Morgenstern H, Cumberland W, Wang C, Mann J, *Health Insurance Coverage of Californians in 1989.* Berkeley: California Policy Seminar, University of California, 1991; and Brown ER, "Trends in Health Insurance Coverage in California, 1989-1993," *Health Affairs*, 1996; 15(1): 120-132.

[2] In 1994, the year covered by the health insurance estimates in the March 1995 Current Population Survey, the federal poverty level was $7,710 for a single nonelderly person, $9,976 for a two-person household, $11,821 for three-person household, and $15,141 for a four-person household.

[3] 1996 KPMG Peat Marwick Employer Health Benefits Survey, unpublished data.

[4] Schauffler H, Brown ER, Rice T. *The Status of Health Insurance in California—1996.* Los Angeles: UCLA Center for Health Policy Research, (forthcoming in 1997).

[5] Donelan K, Blendon RJ, Hill CA, Hoffman C, Rowland D, Frankel M, Altman D. "Whatever Happened to the Health Insurance Crisis in the United States?" *Journal of American Medical Association* 1996; *276*: 1346-1350.

[6] Brown ER, Valdez RB, Wyn R, Yu H, Cumberland W, Policy Report: *Health Insurance Coverage of Californians, 1989-1992*, Los Angeles: UCLA Center for Health Policy Research, March 1994.

[7] One California study estimated that cost shifting by private providers added 15 percent to the premiums of employers. See *Mandating Medical Benefits for California Employees*. San Francisco: William M. Mercer, Inc., 1994.

[8] Holahan J, Coughlin T, Ku L, Lipson DJ, Rajan S. *Insuring the Poor Through Section 1115 Medicaid Waivers. Health Affairs*, 1995 Spring, 14(1):199-216.